South Central Ambulance Service
NHS Foundation Trust

MENTAL CAPACITY ACT (2005) POLICY

DOCUMENT INFORMATION	
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South Central Ambulance Service NHS Foundation Trust
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1. INTRODUCTION & BACKGROUND

South Central Ambulance Service NHS Foundation Trust (the Trust) is committed to delivering an excellent standard of care to all patients. As a Trust, we recognise the increasingly important role the ambulance service holds in regard to advocating for patients that may not have capacity to make decisions for themselves at the point of treatment and will continue to treat everyone fairly, compassionately and holistically.

The principles underlying this policy are in accordance with the Mental Capacity Act (2005) Code of Practice (Department of Health [DH], 2007), Mental Capacity (Amendment) Act (2019), Mental Health Act (1983) Code of Practice (DH, 2015), Human Rights Act (1998), Care Act (2014) and the Equality Act (2010).

2. SCOPE

This policy applies to all employees and workers of South Central Ambulance Service NHS Foundation Trust (SCAS), including secondees into and out of the organisation, volunteers, trainees, contractors, and temporary workers, including those working on a bank or agency contract. For ease of reference, all employees and workers who fall under these groups will be uniformly referred to as 'staff' in this document.

3. AIM

The aim of this policy is for all Trust staff, volunteers and commissioned services (including Private Ambulance Services [PAS] and Voluntary Aid Societies [VAS]) in order to ensure that they are able to comply with the law and DH guidance with regards to the principles of consent and mental capacity assessment when providing care, treatment and transportation of patients.

4. ROLES AND RESPONSIBILITIES

4.1 Trust Board

The Board has ultimate responsibility for ensuring that this policy and associated procedures are in place and complied with to protect patients and service users.

The Board will assure itself of compliance with this policy through the accountability arrangements delegated to the Executive Director of Patient Care and Service Transformation / Chief Nurse and via consideration of the metrics described within the SCAS Safeguarding Dashboard and associated reports to the Quality and Risk Committee and via consideration of an annual safeguarding report prepared by the Associate Director of Safeguarding and endorsed by SCAS Safeguarding Committee.

The Board has ultimate responsibility for ensuring that an effective system for managing any risks associated with safeguarding exists within SCAS and that all staff working in SCAS are aware of and operate within the policy.

4.2 Chief Executive

SCAS Chief Executive (CEO) is ultimately accountable for children's and young people's protection. The CEO provides strategic leadership, ensures that the role and responsibilities of the Board in relation to safeguarding are met, promoting a culture of

supporting good practice and excellence with regard to safeguarding within the organisation and promotes collaborative working with other agencies.

4.3 Executive Director

The Executive Director of Patient Care and Service Transformation / Chief Nurse is the nominated Director at board level responsible for reporting to the Board on safeguarding issues, providing assurance that the organisation is meeting its safeguarding requirements on an annual basis, promoting initiatives to ensure that SCAS has robust arrangements for safeguarding and providing leadership in the long term.

The Executive Director of Patient Care and Transformation / Chief Nurse has individual responsibility for ensuring that a Safeguarding Children policy and associated procedures exist; that both are implemented effectively; that all staff are aware of and operate within the requirements of the policy and procedures and that systems are in place for the effective monitoring of the standards contained within the policy.

4.4 Non-Executive Director

The CEO will align Safeguarding Children to the portfolio of a Non-Executive Director. The Non-Executive Director will act as 'champion' for safeguarding, will ensure appropriate scrutiny of the Trust safeguarding performance and will provide assurance to the Board.

4.5 Managers and Supervisors

4.5.1 The Associate Director of Safeguarding

The Associate Director of Safeguarding will provide strategic leadership and expert practice and support to manage any serious safeguarding issues, will strategically lead operational improvements, innovations and best practice, monitoring the quality and effectiveness of services against performance indicators and standards.

The Associate Director of Safeguarding will apply conflict resolution processes in cases of disagreement regarding thresholds for intervention; will provide support to the Designated Senior Manager in the management of allegations against staff providing expert safeguarding advice as required; will maintain management oversight of significant incidents where there are issues of safeguarding children and ensure dissemination of lessons learnt from safeguarding children practice reviews, multi-agency audit, and domestic homicide reviews involving children and advise on the implementation of recommendations.

The Associate Director of Safeguarding will encourage and nurture a culture of case discussion, reflective practice and the monitoring of significant events at a local level.

4.5.2 Named Practitioners

SCAS is required to have a Named Practitioner for Mental Capacity Act. This is a key role in promoting good professional practice within the organisation providing advice and expertise for staff members and ensuring safeguarding training is in place. The Named Practitioner will work closely with the Executive Director, the Associate Director of Safeguarding and designated health professionals for the health economy and will

be the organisational lead for Mental Capacity in partnership with The Clinical Lead for Mental Health and Learning Disability.

The Named Practitioner will provide highly specialised advice, support, supervision and training, helping to raise the standard and quality of care and improved outcomes. They will also assist SCAS to understand its safeguarding and protection role and responsibilities and meet its statutory duties in line with section the legislative framework.

The Clinical Lead for Mental Health & Learning Disability is responsible for managing the processes and training for the safe and appropriate use of the MCA specific to the ambulance service areas of responsibility within the Trust. This will be developed in line with the SCAS Safeguarding Training Strategy and Training Needs Analysis 2022.

The Operations Directors and Heads of Operations, including PTS managers and 111 leads are responsible and accountable for the day to day safe and appropriate use of the MCA and must ensure that copies of the Mental Capacity Act (2005) Code of Practice, along with all guidance and training materials are available to their staff.

4.5.3 Line managers

Line managers have a responsibility to:

- Contribute to the dissemination and implementation of this policy
- Develop and promote training needs and priorities
- Provide/ensure provision of effective safeguarding appraisal, support, peer review and supervision for staff
- Ensure all staff within their department are aware of this policy and the process to be followed in the event of suspected abuse of a child or young person
- Ensure all staff have access to the appropriate level of training as defined in the SCAS Safeguarding Training Strategy and training needs analysis
- Provide routine management supervision assuring core competencies in safeguarding practice
- Manage any immediate safeguarding and protection issues
- Co-ordinate referral and safe transfer of responsibilities
- Co-ordinate any alternative action plans
- Ensure staff in their areas meet mandatory training requirements in safeguarding and provide support to those making safeguarding referrals

4.6 All staff

All members of staff, including volunteers, have a statutory duty to safeguard and promote the welfare of children and adults, including:

- Adherence to this policy and associated procedures
- All staff are responsible for recognising and responding to allegations of abuse by ensuring that they refer their concerns or assist in the referral
- All staff should contribute to whatever actions are needed to safeguard and promote the welfare of children and young people and take part in regularly reviewing the outcomes for the child or young person against specific plans and outcomes

- Being alert to the possibility of child abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child
- Knowing how to deal with a disclosure or allegation of child /adult abuse
- Undertaking training as appropriate for their role and keeping themselves updated
- Being aware of and following the local policies and procedures they need to follow if they have a child concern
- Ensuring appropriate advice and support is accessed either from managers or SCAS safeguarding team
- Participating in multi-agency working to safeguard the child or adult (if appropriate to role)
- Ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to SCAS policy and procedures and professional guidelines
- Ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

5. LEGAL FRAMEWORK

Responsibilities for safeguarding are enshrined in legislation. This policy has been informed by all relevant guidance (statutory and non-statutory) that seeks to protect children and young people including:

- Mental Capacity Act (2005)
- Mental Capacity Act (2005) Code of Practice
- Mental Capacity (Amendment) Act (2019)
- Mental Health Act (1983)
- Mental Health Act (1983) Code of Practice
- Human Rights Act (1998)
- Equality Act (2010)
- Children Act (2004)
- Care Act (2014)

6. DEFINITIONS

All definitions are explained within the policy.

7. MAIN BODY

7.1 The Mental Capacity Act (2005) Code of Practice

The Mental Capacity Act (2005) Code of Practice provides guidance for a range of people and professionals with differing functions and duties under the MCA and has statutory force.

Certain categories of people/organisations have a legal duty to have regard to the Code when working with or caring for people who lack the capacity to make decisions or to act for themselves. The Code particularly focuses on those who have a duty of care to someone lacking capacity to consent to any care or treatment being provided. That duty of care requires the professional to act in the best interests of the person at all times.

7.2 Principles of the Mental Capacity Act

There are five guiding principles behind the MCA that must be considered when

providing treatment or support for persons lacking capacity. These principles emphasise the fundamental concepts and core values of the MCA.

As stated in the Code, these five guiding principles are:

i. Presumption of Capacity. It must be assumed that every patient that is 16 years or older has the capacity to make their own decisions. A lack of capacity cannot be assumed from an individual having any particular medical condition or disability. Any lack of capacity, and the following need to act on an individual's behalf, must follow a clear decision path and be documented plainly.
ii. Persons have the right to be supported to make their own decision. They must be given all necessary and appropriate help they might require before the conclusion is made that that they are unable to make their own decision.
iii. A person has the right to make a decision that may be viewed by others as 'unwise'. This does not indicate a lack of capacity. However, risk factors and the individual understanding of these will form an aspect of any capacity assessment.
iv. Any actions being taken for, or on behalf of, a person who has been deemed to lack capacity must be done in their best interest. This is set out in the MCA as "An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interest".
v. Any actions being taken for, or on behalf of, a person who has been deemed to lack capacity must be the least restrictive option available at that point and must take into account the rights of the individual and their freedom of action.

When working with an individual that needs to make a decision, it is defined in law that all staff must begin with the presumption that the individual has the capacity to make said decision. Where staff are uncertain, a 2 stage MCA assessment must be completed. Safeguarding should also be considered in all cases when undertaking a mental capacity assessment.

7.3 Assessing Capacity

7.3.1 It is central to the MCA that all adults are presumed to have capacity. If a person has capacity, they have the right to make a decision that appears to be unwise or unsafe, and for this decision to be respected.

7.3.2 There is a clear test set out in the Act for assessing whether an individual lacks capacity to make a particular decision at a particular time. It is always 'decision and time specific' and is known as the 2-stage test. The test is intended to be able to be used to by anyone involved in the care of an individual to determine whether there is capacity in relation to the decision in question.

7.3.3 It is possible for a person's capacity to fluctuate where they may be deemed to have capacity at one point or in regard to a specific decision but not at a further point or regarding a different decision or types of decision. This emphasises the requirement of continuing capacity assessment throughout the episode of care and wherever there is need for a new decision to be introduced.

7.4 Two Stage Test

7.4.1 The 2-stage test consists of the Functional test and the Diagnostic test.

7.4.2 Functional Test: An individual is unable to make a decision for themselves if they are unable to meet any one of the following criteria:

- Understand the information relevant to the decision. (Adjustments should be used as appropriate to assist in understanding)
- Retain that information
- Use or weigh that information as part of the decision-making process
- Communicate their decision (through any communicative means).

7.4.3 Diagnostic Test: Is there an impairment of, or disturbance in the person's mind or brain? (This covers a range of problems, including but not limited to psychiatric illness, emotional distress, learning disability, dementia, brain damage, neurological conditions, the effects of hypoxia, pain or acute behavioural disturbance).

7.4.4 The 'Causative Nexus': Once an impairment or disturbance in the functioning of the mind or brain has been identified, it should be decided whether any ability to make the decision is because of this impairment. This is known as the 'Causative Nexus'. Only where it can be reasonably said that the person cannot make the decision because of the impairment or disturbance can it be said that they lack capacity.

7.4.5 Should there be any question as to whether an individual lacks capacity, this is decided on the balance of probabilities (i.e., being more likely than not).

7.4.6 The presence of a particular medical condition or diagnosis does not automatically result in an individual being 'incapable' or 'lacking capacity'. The 2-stage test must be completed and documented wherever capacity is in question. Documentation should contain all methods of how staff attempted to support the individual to make the decision themselves and provide evidence of how the 2-stage test was carried out.

7.4.7 Where any form of test has been necessary, this should be demonstrated through clear documentation on ePR within the Capacity section with the decision-making process detailed.

7.5 Best Interests

7.5.1 If a patient is deemed as lacking capacity, staff will be required to make a best interest decision on their behalf. Best interest decisions can only be applied to a patient who lacks capacity.

7.5.2 'Best interest' is not defined in the MCA as there are too many different decisions that could be covered by the term.

7.5.3 Best interest decisions must try to be sympathetic to the culture, beliefs and/or any known wishes that the patient held prior to the loss of their capacity, particularly in the case of written statements, if these are possible within an emergency situation.

7.5.4 Where possible, consideration must be made in regard to consultation with friends/family/carers/other HCPs involved with the patient prior to making a best interest decision. Additionally, where there is a possibility that the patient may regain capacity, and it is safe to do so, the option to delay treatment until this might happen should be considered.

7.5.5 Where the decision cannot be delayed, the clinician that undertakes the best interest decision will become the decision maker for the patient. The decision maker must:

- Have taken reasonable steps to assess the individual's capacity to consent to the act/procedure in question
- Believe beyond the balance of probability that the individual lacks the capacity to consent
- Reasonably believe that they are acting in the best interests of the individual concerned.

They must also ensure that they have documented the decision-making process on ePR, detailing:

- How the decision was reached
- What the reason for the decision was
- Who was consulted
- Any other relevant factors taken into account during the process.

7.5.6 Staff are protected under Section 5 of the MCA when carrying out acts of care or treatment in the best interests of a patient who is reasonably believed to lack capacity where they have carried out the correct action, as set out in the Act. Care and treatment actions are not specifically defined within the Act but, within the MCA, treatment includes diagnostic and other procedures.

7.5.7 In emergency situations where a patient appears to have a disturbance or impairment of the mind or brain, but there is no time to carry out a formal capacity assessment – e.g., a patient attempting to run into oncoming traffic or a life-threatening emergency, staff may intervene using the doctrine of necessity under common law. This doctrine allows staff to do what is immediately required in the defined emergency in order to prevent a significant deterioration in the patient's physical or mental wellbeing. The MCA Code of Practice also states that *in emergencies, it will almost always be in the person's best interests to give urgent treatment without delay*. However, it does not allow for intervention outside of that crisis point. Once the patient is safe, the 2-stage capacity assessment would be required prior to any further interventions, or a best interest decision being applied.

7.6 16-17-year Olds

7.6.1 The MCA applies to all people over the age of 16 years and assumes that from this age, all persons have capacity unless shown differently. However, there are certain aspects that do not apply to people within the 16-17 years age bracket:

- Only people aged 18 and over can make a Lasting Power of Attorney
- Only people aged 18 and over can make an advanced decision to refuse medical treatment
- The law does not generally allow anyone under the age of 18 to make a will and the MCA confirms that the Court of Protection has no power to make a statutory

will on behalf of anyone under 18
- DoLS cannot be used with a person under the age of 18.

7.6.2 A child may be safeguarded and protected under the Children Act 1989 until their 18th birthday. However, medical consent, mental capacity, and consent to sexual activity, are lawful from the age of 16. A Gillick Competency Assessment may be used to determine a child's capacity to consent to medical treatment or intervention before the age of 16. The Assessment was designed to test whether a young person prior to their 16th birthday, had sufficient capacity, without parental intervention, to make decisions regarding their own medical treatment.

7.6.3 The Fraser Guidelines were developed specifically in relation to consent for contraceptive or sexual health advice and treatment. Child protection procedures should always be instigated however when child exploitation and or child sexual exploitation is suspected, even if the child or young person is deemed competent.

7.6.4 When carrying out mental capacity assessments with 16-17-year old's, safeguarding should be considered at all times, alongside the Children's Act (1989 and 2004). The safeguarding of a child is paramount, and they must be kept safe and free from harm. Where possible and appropriate, expert guidance can be gained from the Safeguarding Team and Legal Department.

7.7 Restraint

7.7.1 Restraint is defined within Section 6(4) of the MCA as:
- Using force, or threatening to use force, to make someone do something that they are resisting, or
- To restrict a person's freedom of movement, whether they are resisting or not.

7.7.2 The following, non-exhaustive, list covers some of the common techniques used by ambulance staff:
- Placing an arm around the patient and 'steering' them towards the vehicle
- Placing a blanket around the patient and using this to manoeuvre them towards the vehicle
- Securely blanketing a patient and placing a strap across them on a carry chair
- Using straps on the vehicle stretcher (i.e., five-point harness).

7.7.3 Any steps taken must have objective reasoning and justification to show that they are necessary. Staff must demonstrate that the individual being cared for is at a greater risk of harm if proportionate restraint is not used. If any form of restriction is utilised by staff, it must be of the minimum level of intervention for the shortest time possible and, it must be documented clearly on ePR; including details of the technique used and for how long it was used.

7.7.4 If physical restraint has been used, clinicians should ensure that clinical assessment has been carried out post-episode in order to ensure that there have been no injuries sustained. These assessments may include, but are not restricted to, physical observations and body mapping.

7.7.5 If a patient is violent, threatening violence or there is a possibility of a breach of the peace or other associated crime, police must be called to assist. Although this

may cause a delay in the treatment of the patient, the safety of all involved must be considered as a priority. Any delay in the provision of treatment must be documented on ePR.

7.7.6 Failing to use proportionate and appropriate techniques may be considered as a failure to act in the best interests of a patient lacking capacity; this may then constitute ill-treatment or willful neglect under MCA (S.44), which is a criminal offence.

7.8 Involvement of Others

7.8.1 Only two types of people are lawfully empowered to act on the behalf of a person who lacks capacity and are able to make decisions on their behalf. These are either a court appointed deputy or a person holding a Lasting Power of Attorney (LPA) that has been ratified through the Court of Protection.

7.8.2 Court appointed deputies are appointed by the Court of Protection in order to make specific decisions on the behalf of someone that does not have capacity. If there is a known court appointed deputy for health and welfare, they are the decision maker regarding the individual's care and treatment. Deputies are required to follow Principle 4 of the MCA – that they must act in the best interests of the individual and consider their wishes and beliefs prior to losing capacity.

7.8.3 Persons over the age of 18 can give authority, whilst they still maintain capacity, to other people to make decisions on their behalf if they lose capacity to do so for themselves. This is known as Lasting Power of Attorney. If it known that person that does not have capacity has an LPA for health and welfare, that person should be consulted if it is possible to do so. They are the decision maker regarding the individual's care and treatment.
LPAs are required to follow Principle 4 of the MCA as detailed above.

7.8.4 Only people aged 18 and over can be appointed as an attorney or deputy.

7.8.5 If there is any concern that either a court appointed deputy, or LPA, is not acting in the individual's best interest, this should be reported to the Office of the Public Guardian who are responsible for investigating and referring the ongoing matter to the Court of Protection.

7.8.6 LPA/Deputyships in place for financial decisions do not give a right to make health and welfare decisions. And, where a health and welfare LPA/Deputyship is in place and the person in question lacks capacity, the attorney/deputy can only choose from treatment options being offered by the healthcare professional attending. They may not demand a treatment option that is not felt to be in the Best Interest of the patient by the attending crew.

7.8.7 The MCA also introduced the role of Independent Mental Capacity Advocate (IMCA). These are a legal safeguard for people who lack capacity and can be instructed to represent people where there is no-one independent of services, such as a family member or friend, who is able to represent the individual. Where appropriate, their services should be utilised in order to safeguard the best interests of a non-capacious patient. However, where they are not available, this should not delay the provision of any emergency treatment.

7.9 Advance Decisions

7.9.1 An advance decision allows someone aged 18 and over, whilst still capable, to refuse specific medical intervention for some time in the future when they may lack the capacity to consent to or refuse that treatment. The advance decision to refuse treatment must be valid and applicable to the circumstances. If it is, it has the same effect as a decision made by a person with capacity and healthcare professionals must follow that decision.

7.9.2 Healthcare professionals are protected from liability if they:

- Stop or withhold treatment because they reasonably believe that an advance decision exists and that it is valid and applicable.
- Treat a person because, having taken all practicable steps to find out if an advance decision is in place, they are unable to verify either its existence or validity.

7.9.3 If an advance decision refuses life-saving treatment, it must be:

- In writing
- Signed and witnessed, and
- Stating clearly that the decision applies even if life is at risk.

7.9.4 Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is, or is liable to be, detained under the Mental Health Act (1983).

7.10 Deprivation and Protection of Liberty Safeguards

7.10.1 The Deprivation of Liberty Safeguards (DoLS) are a legal framework designed to ensure that those lacking capacity to consent can be deprived of their liberty, lawfully, where this is in their best interest and will protect them from harm.

7.10.2 DoLS apply to those of 18 years – Liberty Protection Safeguards will apply to 16 years and over and are not applicable where a person has capacity.

7.10.3 A deprivation of liberty can occur in a hospital, domestic setting such as supported or independent living or a care home. As such, it is unlikely that ambulance staff will have any immediate involvement unless it is necessary to transfer a person subject to DoLS from one establishment to another (e.g. from a care home to hospital). In situations such as this, staff should ensure that they adhere to the contents of the DoLS and be clear that any actions taken by them comply with the Safeguards. A copy of the Safeguards relating to the individual should also be kept with the person records in the case of a transfer. The Deprivation of Liberty Safeguards Code of Practice can be accessed from the CQC. It should be noted that DoLS is not transferrable between locations and an additional application will be required to be made by those responsible for ongoing care such as the care home or hospital.

7.10.4 The Liberty Protection Safeguards were due to be introduced in April 2022 in the Mental Capacity Amendment Act (2019). However, we are currently awaiting an implementation date. Once LPS have been introduced, they will replace DoLS and introduce some changes to liberty protection and deprivation, at which point this

policy will be reviewed and further guidance issued.

8. TRAINING

SCAS will ensure that all staff receive essential safeguarding training in line with SCAS Safeguarding Training Strategy and Training Needs Analysis 2022 – 2024.

Each area will maintain records of compliance for their own staff in line with the Safeguarding Training Strategy and Training Needs Analysis.

9. EQUALITY AND DIVERSITY

The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees.

The Trust values differences between members of the communities we serve and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences to ensure equality of opportunity and diversity and remove any barriers that could potentially discriminate. Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result. The Trust is entrusted to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

10. MONITORING

SCAS Safeguarding Committee will monitor this policy through a system of audit and case review.

Monitoring and Audit:

Criteria	Method	By	Committee	Frequency
MCA embedding	ePR and Adastra auditing of capacity-related cases	Named Practitioner	Safeguarding	Yearly
MCA training compliance, including reporting of figures and details.	Review of training material. Staff surveys, knowledge reviews and case study-based education input (e.g. podcasts, teaching sessions, Intranet updates)	Named Practitioner	Safeguarding	Yearly

11. CONSULTATION AND REVIEW

This policy document is due for review in one year unless new legislation, a Safeguarding Partnership board(s) directive or learning from a serious incident requires earlier review.

12. IMPLEMENTATION

This policy will be launched by SCAS Safeguarding Service as part of a suite of revised and newly developed safeguarding policies. This will be through a programme of team meetings and seven-minute briefings.

13. REFERENCES AND ASSOCIATED DOCUMENTATION

The following documents are associated with this policy:

- Mental Health Policy
- Mental Health, Dementia & Learning Disability Strategy
- Safeguarding Adults Policy
- Safeguarding Children Policy

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Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: Mental Capacity Act Policy

Officer completing assessment: Matthew Hargreaves

Telephone: 07866 205544

1. What is the main purpose of the strategy, function or policy?
The aim of this policy is to ensure that all Trust staff, volunteers and commissioned services are able to comply with the law and Department of Health guidance with regard to the principles of consent and mental capacity assessment when providing care, treatment and transportation of patients.
2. List the main activities of the function or policy? (for strategies list the main policy areas)
To ensure that the Trust has a robust, clearly defined process to follow to ensure the Trust is complying with the requirements of the Mental Capacity Act, in its dealings with patients.
3. Who will be the main beneficiaries of the strategy/function/policy?
• All SCAS colleagues • Our Patients • The Organisation • Service Commissioners

		Positive Impact	Negative Impact	Reasons
GENDER	Women	x		This policy is designed to provide a logical, clearly defined process to ensure that the Trust is complying with the requirements of the Mental Capacity Act. There is nothing within the policy and procedures that would apply to any groups with protected characteristics in a negative way. If there were circumstances which required any reasonable adjustments or to help realise an equitable outcome the policy is guided by the Equality Statement in Section 9
	Men	x		
RACE	Asian or Asian British People	x		
	Black or Black British People	x		
	Chinese people and other people	x		
	People of Mixed Race	x		
	White/white other	x		
DISABILITY	**Disabled People**	x		Specific consideration is given to any citizen covered by the Mental Capacity Act
SEXUAL ORIENTATION	**Lesbians, gay men and bisexuals**	x		
AGE	Older People (60+)	x		
	Younger People (17 to 25) and children	x		Specific consideration is given to any citizen covered by the Mental Capacity Act
RELIGION/BELIEF	**Faith Groups**	x		
	Equal Opportunities and/or improved relations	x		

Notes: Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

5. If you have indicated that there is a negative impact, is that impact:		
	Yes	**No**
Legal (it is not discriminatory under anti-discriminatory law)	X	
Intended		X
Level of Impact	**High**	**Low**
If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.		X

6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:
If there were circumstances that had a negative impact of low significance or that required any reasonable adjustments or to help realise an equitable outcome the policy is guided by the Equality Statement in Section 9. In addition, there is oversight by the Safeguarding Committee
6(b). Could you improve the strategy, function or policy positive impact? Explain how below:
Continual monitoring of any potential negative impact by the Safeguarding Committee
7. If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How?
This is outlined under section by the Equality Statement in Section 9

Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.
Signed: 27542296
Name: Matthew Hargreaves
Date: 14 November 2022